STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087116	A. BUILDING: _____ B. WING _____	12/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRECIOUS GEMS HOMES AT POLO DR	5502 POLO DRIVE WICHITA, KS 67208

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S 000	INITIAL COMMENTS The following citations represent the findings of an Abbreviated survey with complaint investigations 183614, 183527, 184344, and 184409 for the above named Home Plus facility conducted on 12/4/23 and 12/5/23.	S 000		
S5028 SS=D	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation.	S5028		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S5028	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(3)(A)(B) The facility reported a census of eight residents (R). The sample included three residents. Based on interview and record review for one (R3) of three sampled residents who reported an allegation of sexual assault, the operator failed to report, investigate, and implement measures to protect the resident from potential harm. Findings included: - Review of R3's medical record revealed she moved into the facility on 09/06/23 with diagnoses of bipolar disorder and anxiety. R3's "Functional Capacity Screen" dated 09/06/23 revealed she was independent with all activities of daily living, was unable to manager her medications and medical treatments, had impaired cognition and impaired decision-making. R4's "Negotiated Service Agreement" dated 09/06/23 identified a Certified Medication Aide or Licensed Nurse would provide the resident her medications. It failed to address services related to impaired cognition or decision-making ability. On 10/24/23 the state agency hotline was contacted on behalf of R3 by State Ombudsman D that R3 had been sexually assaulted by a male resident, R4, on three different occasions. The State Ombudsman spoke with Licensed Nurse C	S5028		

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S5028	Continued From page 2 (as indicated in the observation notes on 10/16/23) regarding the residents report of being sexually assaulted. Review of R3's "Observation notes" in the electronic medical record revealed the following documentation: 10/16/23 Licensed Nurse C documented State Ombudsman D contacted her to discuss concerns R3 mentioned, including other residents harassing her. The note did not describe how the resident had been harassed. 11/28/23 Operator/Licensed Nurse A documented she spoke with staff who reported the police came to the facility because R3 reported to the police that R4 was sexually harassing her, but the report was unsubstantiated. On 12/04/23 at 01:18 PM R3 reported two instances where R4 had requested sexual favors and both instances touched her inappropriately without her consent. She stated the first one was on 10/01/23 and the second a few days later. She stated she told Operator/Licensed Nurse A and Owner B about it the day it happened. Interview on 12/04/23 at 02:21 PM, R4 reported the police came and asked questions about the accusations and told us, R3 and myself, to stay away from each other, so he left on Friday to stay with a friend over the weekend. On 12/04/23 at 02:58 PM Operator/Licensed Nurse A reported on Wednesday or Thursday of last week she spoke with staff and was told the police were here because R3 accused R4 of sexually harassing her. She reported she had spoke with R4 who denied anything happened	S5028		

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S5028	Continued From page 3	S5028		

and met with R3's case manager but had not spoken to R3 yet. She also confirmed she did not report it because the police said there was no evidence, so she did not report it.

On 12/05/23 at 10:10 AM Surveyor met with R3, Operator/Licensed Nurse A and State Ombudsman D. Operator/Licensed Nurse A interviewed R3 regarding her accusations about sexual assault. R3 again confirmed that the first incident occurred on 10/01/23 and the second occurred a few nights later. R3 reported she did not report it right away because she thought R4 would get the hint and leave her alone. R3 stated R4 continued to pursue her, made nasty remarks, kept brushing up against her in the hall and that is when she told someone. R3 stated she met with Owner B and Licensed Nurse C and R4. She stated that Owner B and Licensed Nurse C did not believe her and had the two of them, R3 and R4, shake hands. R3 stated administration did nothing after that meeting and expected everything to be OK since they shook hands.

On 12/05/23 at 05:20 PM Licensed Nurse (LN) C confirmed she and Owner B had a meeting a few weeks ago, she could not recall the exact date, with all parties involved. LN C reported after the meeting, Owner B told her there was no need for the accusations to go further, than in-house since they settled it in their meeting.

Review of the "Precious Gems at Polo Homes LLC Policy and Procedures" revised 06/14/19 provided by Operator A on 12/05/23 revealed the following:
Any sexual act with a resident when the resident

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S5028	Continued From page 4 does not consent is considered abuse. Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of Precious Gems at Polo Homes Plus as soon as staff is aware of the allegation, and to the department within 24 hours An investigation shall be started as soon as notification of the alleged violation is received. Immediate measures will be taken to prevent further potential abuse, neglect, or exploitation while the investigation is being handled. Each alleged violation shall be thoroughly investigated within 5 working days of the initial report and a complaint investigation report will be completed and the results reported to the administrator or operator of Precious Gems at Polo Homes Plus. The operator failed to report, investigate, and implement preventative measures when R3 reported another resident had sexually assaulted her.	S5028		
S5300 SS=D	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility.	S5300		

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S5300	Continued From page 5 (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (d) The facility reported a census of eight residents (R). The sample included three residents. Based on record review and interview the operator failed to ensure staff administered medications according to a Medical Providers written order and professional standards of practice for one (R3) of three sampled residents Findings included: - Review of R3's medical record revealed she moved into the facility on 09/06/23 with diagnoses of bipolar disorder and anxiety. R3's "Functional Capacity Screen" dated 09/06/23 revealed she was independent with all activities of daily living, was unable to manager her medications and medical treatments, had impaired cognition and impaired decision-making. R3's "Negotiated Service Agreement" dated 9/6/23 identified a Certified Medication Aide or Licensed Nurse would provide the resident her medications and lacked services related to impaired cognition or decision-making ability. Review of R3's November 2023 Medication	S5300		

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S5300	Continued From page 6	S5300		

Administration Record (MAR) included the following:
On 11/17/23 the MAR directed staff to administer Doxycycline (an antibiotic) 100 milligrams (mg) twice a day for seven days.
On 11/27/23 the MAR directed staff to administer Lisinopril (antihypertensive) 20 mg twice a day.

Review of R3's paper chart and electronic record lacked a medical providers order for the above medications which had been administered by certified staff.

The MAR also included the specific instructions for administration of Zenpep (digestive enzyme) to be given with meals and for Hydroxychloroquine (antimalarial) to be given after Protonix and Zenpep. Her Asenapine (antipsychotic) was to be given an hour after Protonix and Zenpep.

Review of the November MAR documentation of the actual time medications were administered, revealed the above-named medications were all administered at the same time or within a few minutes of each other 34 times.

On 12/05/23 at 01:57 PM Operator/Licensed Nurse A reported she would expect medications to be administered as ordered and if there were specific time frames in comparison of other medications, she expected certified staff to follow directions of the MAR. Operator/Licensed Nurse A looked through R3's paper chart and the electronic record and confirmed she could not find a medical providers order for the administration the Doxycycline and Lisinopril.

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S5300	Continued From page 7 The operator failed to ensure a medical providers order was obtained for all medications the facility was responsible for administering and failed to administer medications according to specific time frames of each other.	S5300		
S5301 SS=E	26-42-205 (d) (3) Facility Administration of Medications (d) (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (d)((3)(D) The facility reported a census of eight residents (R). The sample included 3 residents. Based on record review and interview the Operator failed to ensure the documentation of the administration of medications immediately	S5301		

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S5301	Continued From page 8 before or after completion of the task for two (R3, and R5) of 3 sampled Residents. Findings included: - Review of R3's medical record revealed she moved into the facility on 09/06/23 with diagnoses of bipolar disorder and anxiety. R3's "Functional Capacity Screen" dated 09/06/23 revealed she was independent with all activities of daily living, was unable to manager her medications and medical treatments, had impaired cognition and impaired decision-making. R3's "Negotiated Service Agreement" dated 09/06/23 identified a Certified Medication Aide or Licensed Nurse would provide the resident her medications and lacked services related to impaired cognition or decision-making ability. Review of R3's November 2023 Medication Administration Record (MAR) revealed staff failed to document the administration of or reason why it was not administered for the following medications: Asenapine (antipsychotic) 10 milligrams (mg) 15 out of 60 times. Zenpep (digestive enzyme) 19 out of 90 times. Travoprost eye drops nine out of 30 times. Hydroxychloroquine seven out of 30 times Pantoprazole 14 out of 60 times. Propranolol (antihypertensive) 10 mg 13 out of 56 times and the 20 mg dose three out of 14 times. Ropinirole (for restless legs) .25 mg 18 out of 90 times.	S5301		

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S5301	Continued From page 9	S5301		

Doxycycline (antibiotic) seven out of 14 times.

12/05/23 at 01:57 PM Operator/Licensed Nurse A looked at the MAR and reported she expected staff to initial when the gave the medications and if they do not give it or the resident refuses there is a place for them to document the reason not given.

Review of the "Precious Gems at Polo Homes LLC Policy and Procedures" revised 06/14/19 provided by Operator A on 12/05/23 revealed under the "Medication Administration" section staff were to document the administration of each resident's medication in the resident's medication administration record immediately before or following completion of the task.

The operator failed to ensure qualified staff documented the administration of R3's medications immediately before or after administration.

- Review of R5's medical record revealed she moved into the facility on 07/10/22 with diagnoses of diabetes mellitus type II, hypertension, and reflux disease.

R5's "Functional Capacity Screen" dated 09/08/23 revealed she required physical assistance with management of her medications.

R5's "Negotiated Service Agreement" revealed the resident self injected her insulin, but qualified staff administered all other medications.

Review of the November 2023 "Medication Administration Record" (MAR) revealed that on

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S5301	Continued From page 10 11/01/23 staff failed to initial the administration for all of R5's 08:00 AM or 12:00 PM medications. Gabapentin (for neuropathy) had an additional four times staff did not initial administering the medication. Docusate sodium (for constipation) had an additional five times staff did not initial administering the medication. Spironolactone (diuretic) had an additional three times staff did not initial administering the medication. Metoclopramide (for gastro-intestinal reflux) had an additional five times staff did not initial administering the medication. 12/05/23 at 01:57 PM Operator/Licensed Nurse A reported she expected staff to initial when the gave a medications to a resident and if they do not give it or the resident refused it there is a place for staff to document the reason not given. Review of the "Precious Gems at Polo Homes LLC Policy and Procedures" revised 06/14/19 provided by Operator A on 12/05/23 revealed under the "Medication Administration" section staff were to document the administration of each resident's medication in the resident's medication administration record immediately before or following completion of the task. The operator failed to ensure qualified staff documented the administration of R5's medications immediately before or after administration.	S5301		